

Secondary syphilis with framboesiform facial lesions

A case report

M H BECK,* H C HUBBARD,* V K DAVE,* AND K R HAYE†

From the *Skin Hospital, and †Manchester Royal Infirmary, Manchester

SUMMARY A 15-year-old schoolgirl presented with a generalised progressive skin rash of six months' duration, which had been previously diagnosed as psoriasis. The facial skin lesions were particularly prominent and nodular in form. Serological tests confirmed the diagnosis of secondary syphilis, which responded to treatment.

Introduction

Secondary syphilis is now relatively uncommon, and awareness of its many clinical guises is consequently diminished. A 15-year-old girl with framboesiform facial lesions, referred to us with a diagnosis of psoriasis which was not responding to treatment, is described.

Case report

A 15-year-old schoolgirl was referred to the Manchester Skin Hospital with a generalised skin eruption of six months' duration. Two months before the development of the rash, which began as scaly patches on the arms, there had been a single casual sexual exposure. During the next three months the rash, which was non-irritable, extended to affect the trunk, limbs, palms, and soles. On the face, raised red lesions had developed in the nasolabial folds and over the chin.

Before referral she had been diagnosed as having psoriasis and had been treated with 0.1% fluocortolone pivalate and hexanoate ointment for four weeks, followed by 1% hydrocortisone ointment to the face, and tar and salicylic acid ointment to the trunk and limbs. There was no benefit from the topical treatment.

Her general health remained good and there were no constitutional symptoms. At no time had she received any antibiotic therapy.

EXAMINATION

The patient appeared fit and well and was afebrile. She had a florid rash on the face, which consisted of deep-red, dry, scaling papules and infiltrated nodules

affecting predominantly the nasolabial and chin furrows (fig 1). On the trunk and limbs there was a psoriasiform maculopapular rash consisting of slightly raised, red-brown, oval, scaly lesions up to 3 cms in length (fig 2). Some lesions on the trunk showed early scarring. Fading macules were present on the palms and soles. A few small snail-track ulcers were seen in the mouth. No condylomata lata were present in the perineal or perianal areas. Pelvic examination showed no abnormalities. On general examination there was widespread painless lymph node enlargement but no other abnormality.

LABORATORY INVESTIGATIONS

The haemoglobin was 12.6 g/dl. Erythrocyte sedimentation rate was 55 mm/first-hour, white cell count was $7.0 \times 10^9/l$ with a normal differential count. Urine analysis was normal. Darkfield examination of the snail-track ulcers gave a negative result on three occasions. The results of serological tests were: cardiolipin Wassermann reaction (WR) positive, fluorescent treponemal antibody-absorption (FTA-ABS) test positive, *Treponema pallidum* haemagglutination assay (TPHA) positive at 1/64, and Venereal Disease Research Laboratory (VDRL) test positive at 1/512.

TREATMENT AND COURSE OF ILLNESS

The patient was given intramuscular procaine penicillin, 900 000 units daily for two weeks, followed by fortified benethamine penicillin 1.25 megaunits twice weekly for three weeks.

The lesions showed an immediate response to the course of treatment, and after nine months all the lesions had resolved leaving little scarring on the face but more persistent scarring in a number of areas on the trunk. She remains under periodic observation and serological test results one year after treatment were: WR negative, FTA-ABS test positive, TPHA positive at 1/64, and VDRL test positive at 1/4.

Address for reprints: Dr M H Beck, The Skin Hospital, Quay Street, Manchester M3 3HL

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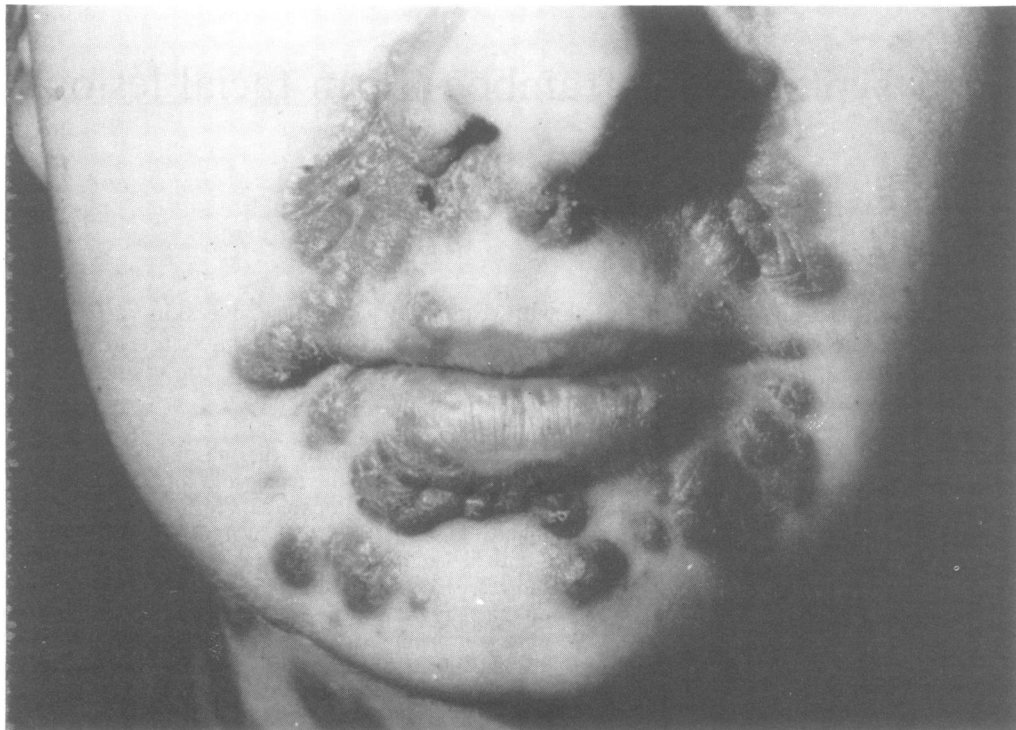


FIG 1 *Framboesiform lesions on the face.*



FIG 2 *Papulosquamous lesions on the trunk.*

Discussion

The older literature provides a very wide spectrum of clinical presentations of secondary syphilis, and the level of diagnostic suspicion must have been higher in the pre-antibiotic era. It is likely that, on occasions, dermatological departments will see undiagnosed or wrongly diagnosed rashes which fail to respond to local treatment, including local corticosteroids, as in the present case.

Our patient showed a number of atypical features of secondary syphilis. The six-month duration of the rash and its progressive nature are not the usual pattern. As a rule, secondary lesions heal without scar formation in 2-10 weeks, even when there is no treatment, although atypical forms are not uncommon.¹ Further relapses over a period of up to five years have been reported in approximately 25% of patients with untreated secondary syphilis.² Of these 90% occurred within one year.

The skin lesions of the patient's trunk fit the classical papulosquamous description,³ but it is unusual for facial lesions to show this degree of

nodularity in secondary syphilis. The term framboesiform has been applied to a number of clinical forms of secondary syphilis⁴ and certainly the colour, size, and shape of these lesions could be described as raspberry-like.

The florid nature of the facial lesions may be related to the use of local corticosteroids on these areas; possibly these modified the local immunological reaction to *T pallidum*. The residual scarring was minimal in this area and is confined to the trunk.

References

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